STATEMENT OF EMERGENCY

907 KAR 1:055E

(1) This emergency administrative regulation is being promulgated to eliminate Medicaid payments to primary care centers in amounts that exceed those approved by the Centers for Medicare and Medicaid Services (CMS) and for which CMS will provide no federal matching funds.

(2) This action must be taken on an emergency basis to prevent a loss of federal funds.

(3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(4) The ordinary administrative regulation is identical to this emergency administrative regulation.

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Steven L. Beshear
Governor

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Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Provider Operations

(Emergency Amendment)

907 KAR 1:055E. Payments for primary care center, federally-qualified health center, federally-qualified health center look-alike, and rural health clinic services.

RELATES TO: KRS 205.560, 216B.010, 216B.105, 216B.130, 216B.990, 42 C.F.R. 413, 438.60, 491, Subpart A, 440.130, 440.230, 447.3251, 45 C.F.R. C.F.R.74.27, 48 C.F.R. Part 31, 42 U.S.C. 1396a, b, d

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(1), 216B.042, 42 U.S.C. 1396a

NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services.~~] The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds[~~for the provision of medical assistance to Kentucky's indigent citizenry. 42 U.S.C. 1396a(aa) establishes requirements for federally-qualified health centers and rural health clinics~~]. This administrative regulation establishes the Department for Medicaid Services' reimbursement poli

cies[~~provisions for reimbursement~~] for primary care center, federally-qualified health center, federally-qualified health center look-alike, and rural health clinic services.

Section 1. Definitions. (1) "Advanced practice registered nurse" or "APRN" is defined by KRS 314.011(7).

(2) "Allowable costs" means costs that are incurred by a federally-qualified health center, federally-qualified health center look-alike, rural health clinic, or primary care center[~~center or clinic~~] that are reasonable in amount and proper and necessary for the efficient delivery of services.

(3)[~~(2)~~] "Audit" means an examination, which may be full or limited in scope, of a federally-qualified health center's, federally-qualified health center look-alike's, rural health clinic's, or primary care center's:

(a) [~~clinic's or center's~~] Financial transactions, accounts, and reports; and

(b) [~~as well as Its~~] Compliance with applicable Medicare and Medicaid regulations, manual instructions, and directives.

[~~(3) "Center" means a federally-qualified health center or a primary care center.~~]

(4) "Change in scope of service" means a change in the type, intensity, duration, or amount of service.

(5) "Clinical psychologist" is defined by 42 C.F.R. 410.71(d)[~~"Clinic" means a rural health clinic~~].

(6) "Department" means the Department for Medicaid Services or its designated agent.

(7) "Enrollee" means a recipient who is enrolled with a managed care organization for the purpose of receiving Medicaid or KCHIP covered services.

(8) "Federally-qualified health center" or "FQHC" is defined in 42 C.F.R. 405.2401.

(9) “Federally-qualified health center look-alike” or “FQHC look-alike” means an entity that is currently approved by the United States Department of Health and Human Services, Health Resources and Services Administration to be a federally-qualified health center look-alike.

(10)[~~(8)~~] "Health care provider" means:

(a) A licensed physician;

(b) A licensed osteopathic physician;

(c) A licensed podiatrist;

(d) A licensed optometrist;

(e) A licensed and certified advanced practice registered nurse[~~-practitioner~~];

(f) A licensed dentist or oral surgeon;

(g) A [~~certified -~~]physician assistant; [~~or~~]

(h) [~~For an FQHC:~~

~~1.~~] A licensed clinical social worker;

(i) A[~~or~~

~~2. A licensed~~] clinical psychologist; or

(j) For an FQHC or FQHC look-alike:

1. A resident in the presence of a teaching physician; or

2. A resident without the presence of a teaching physician if:

a. The services are furnished in an FQHC or FQHC look-alike in which the time spent by the resident in performing patient care is included in determining any intermediary payment to a hospital in accordance with 42 C.F.R. 413.75 through 413.83;

b. The resident furnishing the service without the presence of a teaching physician has completed more than six (6) months of an approved residency program;

c. The teaching physician:

(i) Does not direct the care of more than four (4) residents at any given time; and

(ii) Directs care from a proximity that constitutes immediate availability; and

d. The teaching physician:

(i) Has no other responsibilities at the time;

(ii) Has management responsibility for any recipient seen by the resident;

(iii) Ensures that the services furnished are appropriate;

(iv) Reviews with the resident during or immediately after each visit by a recipient, the recipient's medical history, physical examination, diagnosis, and record of tests or therapies; and

(vi) Documents the extent of the teaching physician's participating in the review and direction of the services furnished to each recipient.

(11)[~~.~~

~~(9)~~] "Interim rate" means a reimbursement amount[~~fee~~] established by the department to pay an[~~a~~] FQHC, FQHC look-alike, RHC, or a PCC[~~primary care center~~] for covered services prior to the establishment of a PPS rate.

(12) "Licensed clinical social worker" means an individual who is currently licensed in accordance with KRS 335.100.

(13) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(14) “Medical Group Management Association Physician Compensation and Production Survey Report” means a report developed and owned by the Medical Group Management Association which:

(a) Highlights the critical relationship between physician salaries and productivity;

(b) Is used to align physician salaries and benefits with provider production;

(c) Contains:

1. Performance ratios illustrating the relationship between compensation and production; and

2. Comprehensive and summary data tables that cover many specialties.

(15)[~~(10)~~] "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(16)[~~(11)~~] "Medicare Economic Index" or "MEI" means the economic index referred to in 42 U.S.C. 1395u(b)(3)(L).

(17) “Parent facility” means a federally-qualified health center, federally-qualified health center look-alike, or primary care center that is:

(a) Licensed and operating with a unique Kentucky Medicaid program provider number;

(b) Operating under the same management as a satellite facility; and

(c) The original facility which existed prior to the existence of a satellite facility.

(18)[~~(12)~~] "PCC" or "primary care center" means an entity that is currently licensed as a PCC in accordance with[~~that has met the licensure requirements established in~~] 902 KAR 20:058.

(19)[~~(13)~~] "Percentage increase in the MEI" is defined in 42 U.S.C. 1395u(i)(3).

(20) “Physician assistant” is defined by KRS 311.840(3).

(21)[~~(14)~~] "PPS" means prospective payment system.

(22)[~~(15)~~] "Rate year" for the purposes of the MEI means the twelve (12) month period beginning July 1 of each year for which a rate is established for an FQHC, FQHC look-alike, RHC, or a PCC[~~a center or clinic~~] under the prospective payment system.

(23)[~~(16)~~] "Reasonable cost" means a cost as determined by the:

(a) Applicable Medicare cost reimbursement principles established[~~set forth~~] in 42 C.F.R. Part 413, 45 C.F.R. 74.27, and 48 C.F.R. Part 31; and

(b) Medical Group Management Association Physician Compensation and Production Survey Report for the applicable year and region.

(24) “Recipient” is defined by KRS 205.8451(9).

(25)[~~.~~

~~(17)~~] "RHC" or "rural health clinic" is defined in 42 C.F.R. 405.2401(b).

(26) “Satellite facility” means a federally-qualified health center, federally-qualified health center look-alike, or primary care center that:

(a) Is at a different location than the parent facility; and

(b) Operates under the same management as the parent facility.

(27) “Telehealth” means two (2)-way, real time interactive between a patient and a physician or practitioner located at a distant site for the purpose of improving a patient’s health through the use of interactive telecommunication equipment that includes, at a minimum, audio and video equipment.

(28)[~~(18)~~] "Visit" means a face-to-face encounter or encounter which occurs via telehealth between a recipient or enrollee[~~patient~~] and a health care provider during which

an[~~a~~] FQHC, FQHC look-alike, RHC, or PCC service is delivered.

Section 2. Provider Participation Requirements. (1) A participating FQHC, FQHC look-alike, RHC, PCC, satellite facility of an FQHC, satellite facility of an FQHC look-alike, or satellite facility of a PCC[~~center or clinic~~] shall be currently:

(a) Enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and

(b) Participating in the Kentucky Medicaid program in accordance with 907 KAR 1:671.

(2)(a) To be initially enrolled with the department, an FQHC, FQHC look-alike, or RHC shall:

1. Enroll in accordance with 907 KAR 1:672; and

2. Submit proof of its certification by the United States Department of Health and Human Services, Health Resources and Services Administration as an FQHC, FQHC look-alike, or RHC.

(b) To remain enrolled and participating in the Kentucky Medicaid program, an FQHC, FQHC look-alike, or RHC shall:

1. Comply with the enrollment requirements established in 907 KAR 1:672;

2. Comply with the participating requirement established in 907 KAR 1:671; and

3. Upon recertification with the United States Department of Health and Human Services, Health Resources and Services Administration as an FQHC, FQHC look-alike, or RHC, submit proof of its continued certification to the department upon obtaining recertification.

(c) The requirements established in paragraph (a) and (b) of this section shall apply

to a satellite facility of an FQHC or FQHC look-alike.

(3)(a) An FQHC, FQHC look-alike, or PCC that operates multiple satellite facilities shall separately enroll each satellite facility with the department in accordance with 907 KAR 1:672.

(b) An FQHC, FQHC look-alike, or PCC that operates multiple satellite facilities shall be authorized to consolidate claims and cost report data of its satellite facilities.

(4) An FQHC, FQHC look-alike, or PCC shall not submit a claim for a service provided at a satellite facility if the satellite facility is not currently:

(a) Enrolled with the department in accordance with 907 KAR 1:672; and

(b) Participating with the department in accordance with 907 KAR 1:671.

(5) An FQHC, FQHC look-alike, RHC, or PCC that has been terminated from federal participation pursuant to 42 C.F.R. 405.2436 shall be terminated from Kentucky Medicaid program participation.

(6)[~~.~~

~~(2) An FQHC shall be enrolled as a primary care center.~~

~~(3)~~] A participating:

(a) FQHC and its staff shall comply with all applicable federal laws and regulations, state laws and regulations, and local laws and regulations regarding the administration and operation of an FQHC;

(b) FQHC look-alike and its staff shall comply with all applicable federal laws and regulations, state laws and regulations, and local laws and regulations regarding the administration and operation of an FQHC look-alike;

(c) RHC and its staff shall comply with all applicable federal laws and regulations,

state laws and regulations, and local laws and regulations regarding the administration and operation of an RHC; or

(d) PCC and its staff shall comply with all applicable federal laws and regulations, state laws and regulations, and local laws and regulations regarding the administration and operation of a PPC.

(7) An FQHC, FQHC look-alike, RHC, or PCC[~~center or clinic and staff shall comply with all applicable federal, state, and local regulations concerning the administration and operation of a PCC, FQHC, or an RHC.~~

~~(4) A center or clinic~~] performing laboratory services shall meet the requirements established in 907 KAR 1:028 and 907 KAR 1:575.

Section 3. Standard Reimbursement for an FQHC, FQHC look-alike, RHC, or PCC.

(1) [~~For services provided on and after July 1, 2001,~~] The department shall reimburse:

(a) A PCC, FQHC, FQHC look-alike, or RHC an all-inclusive encounter rate per patient visit in accordance with a prospective payment system (PPS) as required by 42 U.S.C. 1396a(aa); or

(b) A satellite facility of an FQHC, FQHC look-alike, or PCC an all-inclusive encounter rate per patient visit in accordance with a prospective payment system as required by 42 U.S.C. 1396a(aa).

(2) Except for drugs or pharmacy services, costs related to drugs or pharmacy services shall be excluded from the all-inclusive encounter rate per patient visit referenced in subsection (1) of this section.

(3)[~~.~~

~~(2)~~] The department shall calculate a PPS [~~base~~]rate for[~~:~~

~~(a) An existing center or clinic] in accordance with Section 4 of this administrative regulation; or~~

~~(b)~~] a new FQHC, FQHC look-alike, RCH, or PCC[~~center or clinic~~] in accordance with Section 4[~~5~~] of this administrative regulation.

(4)[~~(3)~~] The department shall adjust a PPS rate per visit:

(a) [~~By fifty (50) percent of the percentage increase in the MEI applicable to primary care services on January 1, 2002;~~

~~(b)~~] By the percentage increase in the MEI applicable to FQHC, FQHC look-alike, RHC, or PCC[~~primary care~~] services on July 1 of each year[~~, beginning July 1, 2002~~]; and

(b)[~~(c)~~] In accordance with Section 7[~~6~~] of this administrative regulation:

1. Upon request and documentation by an FQHC, FQHC look-alike, RHC, or PCC [~~a center or clinic~~] that there has been a change in scope of services; or

2. Upon review and determination by the department that there has been a change in scope of services.

(5)[~~(4)~~] A rate established in accordance with this administrative regulation shall not be subject to an end of the year cost settlement.

Section 4. [~~Establishment of a PPS Base Rate for an Existing Provider.~~

~~(1) The department shall establish a PPS base rate to reimburse an existing PCC, FQHC, and RHC 100 percent of its average allowable cost of providing Medicaid-covered services during a center's or clinic's fiscal years 1999 and 2000. A center's or clinic's fiscal year that ends on January 31 shall be considered ending the prior year.~~

~~(2) A center or clinic shall complete MAP 100601 annually and submit it to the de-~~

~~partment by the last calendar day of the third month following the center's or clinic's fiscal year end.~~

~~(3) The department shall:~~

~~(a) Use a center's or clinic's desk reviewed or audited cost reports for fiscal years ending February 1999 through January 2000 and February 2000 through January 2001;~~

~~(b) Trend the cost from the second base year forward to July 1, 2001 by the percentage of increase as measured by the HCFA hospital market basket index; and~~

~~(c) Calculate the average cost by dividing the total cost associated with FQHC, PCC, and RHC services by the total visits associated with the FQHC, PCC, and RHC services.~~

~~(4) If a center or clinic has only one (1) full year of cost report data, the department shall calculate a PPS base rate using a single-audited cost report.~~

~~(5) The department shall adjust a PPS base rate determined in accordance with this section to account for an increase or decrease in the scope of services provided during fiscal year 2001 in accordance with Section 6 of this administrative regulation.~~

~~(6) Until the establishment of a PPS base rate by the department, a center or clinic shall be paid for services at an interim rate.~~

~~(7) Except for a center that has been receiving an incentive payment, the interim rate shall be the rate on file on June 30, 2001.~~

~~(8) A center that has been receiving an incentive payment shall have an interim rate based upon the average costs of providing services for fiscal years 1999 and 2000. The average shall be calculated in accordance with this section using unaudited cost report data.~~

~~(9) A center shall not be eligible for an incentive payment for services provided on and after July 1, 2001.~~

~~(10)(a) A center or clinic shall have thirty (30) days from the date of notice by the department of its PPS rate to request an adjustment based on a change in scope of services; and~~

~~(b) The department shall have thirty (30) days to review the request prior to establishing a final PPS rate that shall be subject to appeal in accordance with Section 9 of this administrative regulation.~~

~~Section 5.~~] Establishment of a PPS Rate for a New FQHC, FQHC look-alike, RHC, or PCC[~~Base Rate for a New Provider~~].

(1)(a) The department shall establish a PPS [~~base~~] rate to reimburse a new PCC, FQHC, FQHC look-alike, or[~~, and~~] RHC 100 percent of its reasonable cost of providing Medicaid covered services during the FQHC, FQHC look-alike, or RHC's[~~a center's or clinic's~~] base year.

(b) Except for a time frame in which the department reimburses an FQHC, FQHC look-alike, RHC, or PCC an interim rate, the initial and subsequent final PPS rate established for an FQHC, FQHC look-alike, RHC, or PCC shall:

1. Be prospective; and

2. Not settled to cost.

(2)(a) The department shall determine the reasonable costs of an FQHC, FQHC look-alike, RHC, or PCC based on the cost reported which contains twelve (12) full months of operating data most recently submitted to the department by the FQHC, FQHC look-alike, RHC, or PCC.

(b) The base rate referenced in subsection (1)(a) of this section shall be based on the reasonable cost determination made by the department pursuant to paragraph (a) of this subsection.[~~(2) Reasonable costs shall be determined by the department based on a center's or clinic's cost report used by the department to establish the PPS rate~~].

(3)(a) Until an FQHC, FQHC look-alike, or RHC[~~a center or clinic~~] submits a Medicaid cost report containing twelve (12) full months of operating data for the facility's base[~~a fiscal~~] year, the department shall reimburse the[~~make payments to the~~] FQHC, FQHC look-alike, or RHC[~~center or clinic based on~~] an interim rate equal to the per diem rate established for the FQHC, FQHC look-alike, or RHC by Medicare.

(b) An FQHC, FQHC look-alike, or RHC shall provide the department with a copy of the Medicare rate letter for the rates in effect during the FQHC, FQHC look-alike, or RHC's interim period.

(c)1. The department shall adjust an interim rate for an FQHC, FQHC look-alike, or RHC based on the establishment of the final rate.

2. All claims submitted to the department and paid by the department based on the interim rate shall be adjusted to comport with the final rate.

(d)1. Until a PCC submits a Medicaid cost report containing twelve (12) full months of operating data for the facility's base year, the department shall reimburse the PCC an interim rate equal to the average PPS rate paid to PCCs in the same region in which the PCC is located.

2. The department shall adjust an interim rate for a PCC based on the establishment of the final rate.

3. All claims submitted to the department and paid by the department based on the

interim rate shall be adjusted to comport with the final rate.

(4)(a) An FQHC, FQHC look-alike, RHC, or PCC shall submit an annual cost report to the department by the end of the fifth month following the end of the FQHC's, FQHC look-alike's, RHC's, or PCC's first full fiscal year.

(b) The department shall:

1. Review an annual cost report submitted by an FQHC, FQHC look-alike, RHC, or PCC within ninety (90) business days of receiving the cost report; and

2. Notify the FQHC, FQHC look-alike, RHC, or PCC of the:

a. Necessity of the FQHC, FQHC look-alike, RHC, or PCC to submit additional documentation if necessary;

b. Final rate established;

c. Appeal rights regarding the final rate; and

d. Estimated time for determining a final rate if a final rate is not established within ninety (90) days;

(c)1. If additional documentation is necessary to establish a final rate, the FQHC, FQHC look-alike, RHC, or PCC shall:

a. Provide the additional documentation to the department within thirty (30) days of the notification of need for additional documentation; or

b. Request an extension beyond thirty (30) days to provide the additional documentation.

2. The department shall grant no more than one (1) extension.

3. An extension shall not exceed thirty (30) days.

(d) If the department requests additional documentation from an FQHC, FQHC look-

alike, RHC, or a PCC but does not receive additional documentation or an extension request within thirty (30) days, the department shall reimburse the FQHC, FQHC look-alike, RHC, or PCC based on the Medicaid physician fee schedule applied to physician services pursuant to 907 KAR 3:010 until:

1. The additional documentation has been received by the department; and

2. The department has established a final rate.

Section 5. Reimbursement for Services Provided to an Enrollee by a PCC That is Not an FQHC, FQHC look-alike, or RHC. (1) For a visit by an enrollee to a PCC that is not an FQHC, FQHC look-alike, or RHC, the PCC's reimbursement shall be the reimbursement established pursuant to an agreement between the PCC and the managed care organization with whom the enrollee is enrolled.

(2) The department shall not supplement the reimbursement referenced in subsection (1) of this section.

Section 6. Supplemental Reimbursement for FQHC services, FQHC look-alike services, and RHC services. If a managed care organization's reimbursement to an FQHC, FQHC look-alike, or RHC for a visit by an enrollee to the FQHC, FQHC look-alike, or RHC is less than what the FQHC, FQHC look-alike, or RHC would receive pursuant to Sections 3 and 4 of this administrative regulation, the department shall supplement the reimbursement made by the managed care organization in a manner that:

(1) Equals the difference between what the managed care organization reimbursed and what the reimbursement would have been if it been made in accordance with Sections 3 and 4 of this administrative regulation;

(2) Is in accordance with 42 U.S.C. 1396a(bb)(5)(A); and

(3) Ensures that total reimbursement does not exceed the federal upper payment limit in accordance with:

a. 42 C.F.R. 447.304; and

b. 42 C.F.R. 447.321.[~~.~~

~~(4) A new center or clinic shall submit a budget that sets forth:~~

~~(a) Estimates of Medicaid allowable costs to be incurred by the center or clinic during the initial reporting period of at least twelve (12) months; and~~

~~(b) The number of Medicaid visits a center or clinic expects to provide during the reporting period.~~

~~(5) An interim payment shall be based on an annual budgeted or projected average cost per visit that shall be subject to reconciliation after a Medicaid cost report with twelve (12) months of actual operating data has been received.~~]

Section 7. Change in Scope and PPS Rate Adjustment. [~~6. Adjustments to a PPS Rate.~~]

(1) If an FQHC, FQHC look-alike, RHC, or PCC[~~a center or clinic~~] changes its scope of services after the base year, the department shall adjust the FQHC's, FQHC look-alike's, or RHC's[~~a center's or clinic's~~] PPS rate.[~~ by dividing a center's or clinic's total Medicaid costs by total Medicaid visits. A provider shall submit MAP 100501 to request a rate adjustment after a change in service.~~]

(2) A change in scope of service shall be restricted to:

(a) Adding or deleting a covered service;

(b) Increasing or decreasing the intensity of a covered service; or

(c) A statutory or regulatory change that materially impacts the costs or visits of an

FQHC, FQHC look-alike, RHC, or PCC.

(3) The following individually shall not constitute a change in scope:

(a) A general increase or decrease in the costs of existing services;

(b) An expansion of office hours;

(c) An addition of a new site that provides the same Medicaid covered services;

(d) A wage increase;

(e) A renovation or other capital expenditure;

(f) A change in ownership; or

(g) An addition or deletion of a service provided by a non-licensed professional or specialist.

(4) An addition or deletion of a covered service shall be restricted to the addition or deletion of a licensed professional staff member who can perform a Medicaid covered service that is not currently being performed within the FQHC, FQHC look-alike, or RHC by a licensed professional employed or contracted by the facility.

(5) A change in intensity shall:

(a) Include a material change;

(b) Increase or decrease the existing PPS rate by at least five (5) percent; and

(c) Last at least twelve (12) months.

(6) The department shall consider a change in scope request due to a statutory or regulatory change that materially impacts the costs of visits at an FQHC, FQHC look-alike, or RHC if:

(a) A government entity imposes a mandatory minimum wage increase and the increase was not included in the:

1. Calculation of the final PPS rate; or

2. Subsequently included in the MEI applied yearly; or

(b)1. A new licensure requirement or modification of an existing requirement by the state results in a change that affects all facilities within the class.

2. A provider shall document that an increase or decrease in the cost of a visit occurred as a result of a licensure requirement or policy modification.

(7) A requested change in scope shall:

(a) Increase or decrease the existing PPS rate by at least five (5) percent;

(b) Last at least twelve (12) months.

(8) For a change in scope that is effective during a base year for determining an FQHC's, FQHC look-alike's, or RHC's final PPS rate, the base year costs associated with the change in scope shall not be duplicated when determining the revised PPS rate due to the change in scope.

(9) The following documents shall be submitted to the department within six (6) months of the effective date of a change in scope:

(a) A narrative describing the change in scope;

(b) A projected cost report containing twelve (12) months of data for the interim rate change; and

(c) A completed MAP 100501, Prospective Payment System Rate Adjustment.

(10) The department shall:

(a) Review the documentation listed in subsection (9) of this section; and

(b) Notify the FQHC, FQHC look-alike, or RHC in writing of the approval or denial of the request for change in scope within ninety (90) business days.

(11)(a) If the department requests additional documentation to calculate the rate for a change in scope, the FQHC, FQHC look-alike, or RHC shall:

1. Provide the additional documentation to the department within thirty (30) days of the notification of need for additional documentation; or

2. Request an extension beyond thirty (30) days to provide the additional documentation.

(b)1. The department shall grant no more than one (1) extension.

2. An extension shall not exceed thirty (30) days.

Section 8. Regions. The following shall be the regions used to determine a PCC's regional location for the purpose of determining a new PCC's interim rate:

(1) Region one (1) shall be the region containing Ballard, Caldwell, Calloway, Carlisle, Crittenden, Fulton, Graves, Hickman, Livingston, Lyon, Marshall, and McCracken Counties;

(2) Region two (2) shall be the region containing Christian, Daviess, Hancock, Henderson, Hopkins, McLean, Muhlenberg, Ohio, Trigg, Todd, Union, and Webster Counties;

(3) Region three (3) shall be the region containing Breckenridge, Bullitt, Carroll, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, and Washington Counties;

(4) Region four (4) shall be the region containing Adair, Allen, Barren, Butler, Casey, Clinton, Cumberland, Edmonson, Green, Hart, Logan, McCreary, Metcalfe, Monroe, Pulaski, Russell, Simpson, Taylor, Warren, and Wayne Counties;

(5) Region five (5) shall be the region containing Anderson, Bourbon, Boyle, Clark,

Estill, Fayette, Franklin, Garrard, Harrison, Jackson, Jessamine, Lincoln, Madison, Mercer, Montgomery, Nicholas, Owen, Powell, Rockcastle, Scott, and Woodford Counties;

(6) Region six (6) shall be the region containing Boone, Campbell, Gallatin, Grant, Kenton, and Pendleton Counties;

(7) Region seven (7) shall be the region containing Bath, Boyd, Bracken, Carter, Elliott, Fleming, Greenup, Lawrence, Lewis, Mason, Menifee, Morgan, Robertson, and Rowan Counties; and

(8) Region eight (8) shall be the region containing Bell, Breathitt, Clay, Floyd, Harlan, Johnson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley, and Wolfe Counties.[~~Total Medicaid costs shall be determined in accordance with the following:~~

~~(a) The Medicaid costs of existing services shall be determined by multiplying a center's or clinic's current Medicaid PPS rate by the number of Medicaid visits used to calculate the base Medicaid PPS rate; and~~

~~(b) The Medicaid costs of a new service shall be determined by:~~

~~1. Adding:~~

~~a. The projected annual direct cost of a new service as determined from a center's or clinic's budgeted report; and~~

~~b. The administrative cost of a new service which shall be equal to the ratio of administrative costs to direct costs determined from the base-year cost reports multiplied by a center's or clinic's projected direct cost of a new service; and~~

~~2. Multiplying the sum derived in subparagraph 1 of this paragraph by a center's or clinic's projected Medicaid utilization percentage for the change in service.~~

~~(3) The amount determined in subsection (2)(a) of this section shall be added to the amount determined in subsection (2)(b) of this section.~~

~~(4) The amount determined in subsection (3) of this section shall be divided by total visits to derive a center's or clinic's new PPS rate.~~

~~(5) Total Medicaid visits shall include:~~

~~(a) The annual number of Medicaid visits used in the calculation of the PPS base rate; and~~

~~(b) The projected annual number of Medicaid visits for a new service.~~

~~(6) The department shall adjust the PPS rate determined under this section to a final rate upon completion of:~~

~~(a) A Medicaid comprehensive desk review of a center's or clinic's cost report;~~

~~(b) A Medicaid audit of a center's or clinic's cost report in accordance with 45 C.F.R. 74.27 and 48 C.F.R. Part 31; or~~

~~(c) A Medicare audit that has been reviewed and accepted by Medicaid of a center's or clinic's cost report.~~]

Section 9.[~~7.~~] Limitations. (1) Except for a case in which a recipient or enrollee[~~patient~~], subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment, an encounter with more than one (1) health care provider and multiple encounters with the same health care provider which take place on the same day and at a single location shall constitute a single visit.

(2) A vaccine available without charge to an[~~a~~] FQHC, FQHC look-alike, RHC, or PCC through the department's Vaccines for Children Program and the administration of the vaccine shall not be reported as a cost to the Medicaid Program.

Section 10.[~~8.~~] Out-of-State Providers. Reimbursement to an out-of-state FQHC, FQHC look-alike, or RHC shall be the rate on file with the FQHC's, FQHC look-alike's, or RHC's[~~their~~] state Medicaid agency.

Section 11.[~~9.~~] Appeal Rights. (1) An appeal of a negative action taken by the department regarding a Medicaid beneficiary shall be in accordance with 907 KAR 1:563.

(2) An appeal of a negative action taken by the department regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) An[~~A~~] FQHC, FQHC look-alike, PCC, or RHC may appeal a department decision[~~decisions~~] as to the application of this administrative regulation as it impacts the facility's reimbursement rate in accordance with 907 KAR 1:671.

Section 12.[~~10.~~] Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "MAP 100501, Prospective Payment System Rate Adjustment," November 2008 edition[~~November, 2001 edition"~~]; and

(b) "Instructions for Completing the MAP 100501 Form", February 2013 edition[~~"MAP 100601, Scope of Services Survey Baseline Documentation, November, 2001 edition"~~].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (Recodified from 904 KAR 1:055, 5-2-86; Am. 13 Ky.R. 389; eff. 9-4-86; 15 Ky.R. 1326; eff. 12-13-88; 1981; eff. 3-15-89; 16 Ky.R. 281; eff. 9-20-89; 2601; eff. 6-27-90; 18 Ky.R. 543; eff. 10-6-91; 29 Ky.R. 824; 1279; eff. 10-16-02.)

907 KAR 1:055E

REVIEWED:

Date

Lawrence Kissner, Commissioner
Department for Medicaid Services

APPROVED:

Date

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 1:055E
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the Department for Medicaid Services (DMS) reimbursement policies for Medicaid covered services provided by a federally-qualified health center (FQHC), rural health clinic (RHC), or primary care center (PCC) that is not an FQHC, FQHC look-alike, or RHC. An FQHC or FQHC look-alike is a federally-recognized entity that serves a population that is medically underserved. An RHC is a federally-recognized entity that is designated or certified by the secretary of the Department of Health and Human Services as being located in an area that is a health professional shortage area or medically underserved area. A PCC is an entity whose licensure requirements are established by the Cabinet for Health and Family Services Office of Inspector General pursuant to 902 KAR 20:058 and are not federally-recognized as being equivalent to an FQHC.
(b) The necessity of this administrative regulation: The administrative regulation is necessary to establish the Department for Medicaid Services (DMS) reimbursement policies for Medicaid covered services provided by an FQHC, RHC, or PCC (that is not an FQHC, FQHC look-alike, or RHC.)
(c) How this administrative regulation conforms to the content of the authorizing statutes: The administrative regulation conforms to the content of the authorizing statutes by reimbursing for Medicaid covered services provided by an FQHC, RHC, or PCC in a manner which ensures the receipt of federal funding for the reimbursement.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by reimbursing for Medicaid covered services provided by an FQHC, RHC, or PCC in a manner which ensures the receipt of federal funding for the reimbursement.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The amendment eliminates supplemental payments (in addition to payments that PCCs receive from managed care organizations) to PCCs for services provided to managed care organization enrollees. Additional amendments include elaborating on the enrollment/participation process and requirements; establishing that DMS will reimburse a new PCC an interim rate equal to the average rate to PCCs in the region in which the PCC is located (currently DMS pays an interim rate based on projected costs submitted to DMS by the PCC); elaborating on re-

imbursement requirements such as cost report requirements; clarifying policy; inserting criteria for what constitutes a change in scope; and eliminating obsolete statements.

(b) The necessity of the amendment to this administrative regulation: The primary amendment is necessary to prevent a loss of federal funding for services provided by primary care centers that are not federally qualified health centers, federally-qualified health center look-alikes, or rural health clinics. The Centers for Medicare and Medicaid Services (CMS) issued a letter to the Department for Medicaid Services "deferring" (declining to provide federal matching funds) for supplemental payments made by DMS to PCCs (that are not FQHCs) for the most recently finalized quarterly expenditure period (July 1, 2012 through September 30, 2012.) CMS stated that the PCCs to which DMS provides supplemental payments are being "improperly classified" as FQHCs, FQHC look-alikes, or RHCs as they have not been designated by the Health Resources and Services Administration (HRSA) as FQHCs or FQHC look-alikes nor have they been certified as RHCs. The supplemental payments represent payments DMS made to PCCs above what the PCCs were reimbursed by managed care organizations for services provided to managed care enrollees. DMS has been reimbursing PCCs the difference (on a per claim basis) between what DMS paid to PCCs prior to managed care implementation and what PCCs receive from managed care organizations. CMS indicates that the supplemental payments violate 42 U.S.C. 1396a(bb)(5)(A) and 42 C.F.R. 438.60 and that PCC reimbursement (as they are not FQHCs, FQHC look-alikes or RHCs) cannot be supplemented by DMS above what the PCCs receive from managed care organizations. As CMS will not provide federal matching funds for the supplemental payments, DMS is amending the regulation to protect Kentucky taxpayer funds from being used to offset the loss of federal funds and to ensure that DMS operates within the fiscal parameters established by the Kentucky General Assembly and Governor via the biennium budget (in accordance with the Kentucky Constitution.) The amendment to a PCC's interim rate is necessary due to some PCC's submitting extraordinarily high projected costs to DMS, for interim rate purposes, compared to what the actual costs experienced by the PCC proved to be over the first full year of costs. The amendment helps ensure that DMS pays a reasonable interim rate on the front end and minimizes the possibility of a PCC receiving an exorbitant amount (in contrast to actual costs) of reimbursement on the front end.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by preventing a loss of federal funds for reimbursement to PCCs, by protecting Kentucky taxpayer funds from being used to offset the loss of federal fund, and by ensuring that DMS operates within the fiscal parameters established by the Kentucky General Assembly and Governor via the biennium budget (in accordance with the Kentucky Constitution.)

(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by preventing a loss of federal funds for reimbursement to PCCs, by protecting Kentucky taxpayer funds from being used to offset the loss of federal fund, and

by ensuring that DMS operates within the fiscal parameters established by the Kentucky General Assembly and Governor via the biennium budget (in accordance with the Kentucky Constitution.)

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The Centers for Medicare and Medicaid Services identified 107 primary care centers that do not qualify as FQHCs, FQHC look-alikes, or RHCs and to which DMS is to cease providing supplemental payments.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Any primary care center that is not a federally-qualified health center (FQHC) or FQHC look-alike and wishes to be reimbursed in the same manner as an FQHC or FQHC look-alike will have to apply to the United States Department of Health and Human Services (USDHHS), Health Resources and Services Administration (HRSA) and be designed by HRSA as an FQHC or FQHC look-alike. Similarly, any PCC that wishes to be reimbursed in the same manner as an RHC must complete the steps necessary to be federally certified as an RHC.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed by the amendment, but any PCC who does not become an FQHC, FQHC look-alike, or RHC will no longer receive supplemental payments.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A PCC which applies and is approved by HRSA as an FQHC or FQHC look-alike or is certified as an RHC will benefit by receiving an enhanced reimbursement for services provided.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: The amendment is necessary to prevent DMS from losing $8.7 million in federal taxpayer matching funds for supplemental payments to PCCs for the July 1, 2012 to September 30, 2012 quarter. The Centers for Medicare and Medicaid Services (CMS) has indicated it will no longer provide federal matching funds for supplemental payments to PCCs who are not FQHCs, FQHC look-alikes, or RHCs. DMS hopes to avoid any loss of federal funds but the amount lost depends partly on the adoption of the amendment.
(b) On a continuing basis: The amendment is necessary to prevent DMS from losing $8.7 million in federal taxpayer matching funds for supplemental payments to PCCs for the July 1, 2012 to September 30, 2012 quarter. The Centers for Medicare and Medicaid Services (CMS) has indicated it will no longer provide federal matching funds for supplemental payments to PCCs who are not FQHCs, FQHC look-alikes, or RHCs. DMS hopes to avoid any loss of federal funds but the

amount lost depends partly on the adoption of the amendment.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Federal funds authorized under the Social Security Act, Title XIX and state matching funds from general fund and restricted fund appropriations are utilized to fund the this administrative regulation.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding is necessary to implement the amendment.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used.) Tiering is applied in the sense that primary care centers that are not an FQHC, FQHC look-alike, or RHC will not be reimbursed in the same manner as those entities as the Centers for Medicare and Medicaid Services (CMS) has stated that such payments violate federal law and regulation and are ineligible for federal matching funds. .

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:055E
Agency Contact: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(bb)(5)(A) and 42 C.F.R. 438.60 mandate the amendment.

2. State compliance standards. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry.

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396a(bb)(5)(A) only authorizes federally-qualified health centers (FQHCs), FQHC look-alikes, or RHCs to receive Medicaid reimbursement in addition to reimbursement they receive pursuant to a contract between the FQHC, FQHC look-alike, or RHC and a managed care organization. 42 C.F.R. 438.60 establishes that no Medicaid reimbursement may be made to a provider who is a provider with a managed care organization in addition to what the provider receives from the managed care organization except for delineated exceptions. Payments to PCCs who are not FQHCs, FQHC look-alikes, or RHCs do not qualify as any of the exceptions.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? This administrative regulation does not set stricter requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Neither stricter nor additional standards nor responsibilities are imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 1:055E
Agency Contact Person: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 438.60 and this administrative regulation authorize the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS projects no revenue will initially be generated by the amendment to this administrative regulation.
   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS projects no revenue will be generated in subsequent years by the amendment to this administrative regulation.
   (c) How much will it cost to administer this program for the first year? The amendment is necessary to prevent DMS from losing $8.7 million in federal matching taxpayer funds for supplemental payments to PCCs for the July 1, 2012 to September 30, 2012 quarter. The Centers for Medicare and Medicaid Services (CMS) has indicated it will no longer provide federal matching funds for supplemental payments to PCCs who are not FQHCs, FQHC look-alikes, or RHCs. DMS hopes to avoid any loss of federal funds but the amount lost depends partly on the adoption of the amendment.
   (d) How much will it cost to administer this program for subsequent years? The amendment is necessary to prevent DMS from losing $8.7 million in federal taxpayer matching funds for supplemental payments to PCCs for the July 1, 2012 to September 30, 2012 quarter. The Centers for Medicare and Medicaid Services (CMS) has indicated it will no longer provide federal matching funds for supplemental payments to PCCs who are not FQHCs, FQHC look-alikes, or RHCs. DMS hopes to avoid any loss of federal funds but the amount lost depends partly on the adoption of the amendment

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.
Revenues (+/-):

Expenditures (+/-):
Other Explanation

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:055E

Summary of Material Incorporated by Reference

The “MAP 100501, Prospective Payment System Rate Adjustment”, November, 2008 edition replaces the November 2001 edition of the form. The form contains one (1) page and must be completed by a facility whenever the facility requests a change in scope. The form helps determine whether the facility needs an adjustment to its prospective payment system rate. The form has been reformatted, contains a new section for totals, contains a new area near the top of the form for providers to state their name, Medicaid provider number, reason for change in scope, and effective date of change in scope. The form also contains some terminology changes.

The “Instructions for Completing the MAP 100501 Form”, February 2013 edition is a new form that is incorporated by reference. This is a two (2)-page form which explains how to complete a MAP 100501.

DMS is deleting the "MAP 100601, Scope of Services Survey Baseline Documentation”, November, 2001 edition from the incorporated material as it is no longer used.

The material incorporated by reference encompasses a total of three (3) pages.